Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Replaces VHA Directive 2001-007

VHA DIRECTIVE 2002-002

January 23, 2002

MEDICAL CARE FY 2002 NETWORK ALLOCATION

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy and procedures for the Fiscal Year (FY) 2002 Network Allocations and their use. ***NOTE:*** *The President of the United States' budget is the basis for the allocation of funds to VHA Networks. Future adjustments, depending on Congressional action, may be required.*

2. BACKGROUND: The vast majority of the Network Allocations are prepared using a prospective payment funding system called the Veterans Equitable Resource Allocation (VERA) system. VERA was implemented in April 1997, and will continue to be used for the FY 2002 Network Allocation.

3. POLICY: It is VHA policy that the process concerning the allocation of funding to Networks is to follow the specific instructions pertaining to programs which have unique funding requirements as found in Attachment A and Attachment B.

4. ACTION

a. **Format**

(1) The FY 2002 Network Allocation will be prepared by the VHA Office of Finance (172). Data to populate the Network Allocation will be provided as follows:

(a) Section I - Allocation Resource Center.

(b) Section II – Assistant Deputy Under Secretary for Health.

(2) Network Allocations will be provided at the Veterans Integrated Services Network (VISN) level. Each VISN will establish an appropriate initial contingency reserve based on historical experience. Initial fiscal year Network Allocations to facilities are at the discretion of the Networks and must be developed in accordance with VHA Directive 97-054 (Network Resource Allocation Principles) and submitted to VHA Office of Finance (172) no later than 21 calendar days after a VISN receives its final FY 2002 allocation. Within 1 week after approval by VHA Central Office, each VISN must provide a quarterly distribution of their facilities budgets to the Resource Allocation and Analysis Office (172) for input into the Automated Allotment Control System (AACS).

b. **Instructions**. Attachment A provides Network Allocation line item explanations and general guidelines for their application. Attachment B provides a list of commonly used terms and their definitions.

THIS VHA DIRECTIVE EXPIRES SEPTEMBER 30, 2002

5. REFERENCES

a. VHA Supplement to MP-4, Part VII.

b. Office of Management and Budget (OMB) Circular A-34.

6. FOLLOW-UP RESPONSIBILITY: The VHA Chief Financial Officer (17) is responsible for the contents of this directive.

7. RESCISSION: VHA Directive 2001-007 is rescinded. This Directive expires September 30, 2002.

Thomas L. Garthwaite, M.D.
Under Secretary for Health

Attachments

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ATTACHMENT A

FISCAL YEAR 2002 NETWORK ALLOCATION EXPLANATIONS AND GUIDELINES

1. FISCAL YEAR (FY) 2002 VETERANS EQUITABLE RESOURCE ALLOCATION (VERA)

a. Approximately 85 percent of the FY 2002 Medical Care appropriation will be distributed to the Networks in Section 1 of the FY 2002 Network Allocation using the VERA system.

b. Funds will be allocated through VERA's six model components: Basic Vested Care and Basic Non-vested Care, Complex Care, Research Support, Education Support, Equipment, and Non-recurring Maintenance.

c. The veteran count that is used for the allocations is adjusted to reflect the location of the care given. Each veteran's care is pro-rated among the Veterans Integrated Service Networks (VISNs) which are expected to participate in their care. This pro-ration technique is referred to as Pro-Rated Persons (PRPs).

d. The pool of resources that is allocated by VERA consists of resources for all activities allocated in the FY 2001 Network Allocation Section I affected by the rate of change in the Medical Care appropriation, plus additional programs, listed in paragraph 3.L of FY 2001 Network Allocation Section I, that have been moved from Specific Purpose to General Purpose. ***NOTE:*** *It should be noted that these resources ordinarily will not be supplemented during the year by Veterans Health Administration (VHA) Central Office, therefore VISNs must plan accordingly. However, VHA has developed a process for evaluating supplemental funding requests in the event Network Directors encounter funding problems during the year.*

e. The VHA Office of Finance, via the Allocation Resource Center, will distribute additional supportive reports in conjunction with the FY 2002 Network Allocation that provides details for the allocation process and performance data that could be of assistance in maximizing Network resources.

f. **Basic Vested Care and Basic Non-vested Care.** The issue to distinguish between the fully-vested patient and the occasional user was refined for the FY 2000 Network Budget Allocation. The Department of Veterans Affairs (VA)'s goal was to determine what constitutes a fully-vested patient, even with one visit, and fund those patients at the full Basic Care price. A description was needed for the limited user that was not based on the number of care encounters (clinic visits and/or medical facility stays). As a result, beginning for FY 2000, VA decided that Basic Care patients consist of two groups: fully-vested, those who rely on VA for their care and non-vested, those who use some VA health care services, but are less reliant on the VA system. A patient is considered fully vested in the veterans health care system if the patient has used inpatient services or if the patient received an appropriate, detailed medical evaluation during the past 3 years. This is determined through the presence of a Current Procedural Terminology (CPT) code that is inclusive of an appropriate medical evaluation. By applying relevant CPT codes to outpatients seen in FYs 1998, 1999, and 2000, vested patients have been identified for

FY 2002. A separate price for each category has been established in VERA to determine network allocations. Veteran users are defined as all mandatory (category A, category X, and Compensation and Pension exams) users the VISN has seen over a 3-year period (FY 1998 through FY 2000). ***NOTE:*** *Veteran user data was prepared by the Office of Policy and Planning.*

g. **Complex Care.** Complex Care funding resources will be allocated to each VISN using a single national price per Complex Care patient user multiplied by the forecasted FY 2002 count of Complex Care patient users at each VISN. Complex Care patients are defined as the projected number of Complex Care patients that the VISN will care for in FY 2002 based upon historical demand from FY 1996 through FY 2000. In FY 2001, the Complex Care projection methodology changed to delete the veteran population factor from the calculation and the projection is now based on historical experience and the impact of age. ***NOTE:*** *The VHA Office of Finance prepared Complex Care patient forecasts.*

h. **Hepatitis C**. The identification, care, and treatment of Hepatitis C patients have become critical subjects in VA. Hepatitis C Virus (HCV) infection is now recognized as a serious national problem and is more prevalent in the veteran population. HCV is a complicated condition that requires a high demand on staff and in cases of active treatment, has a high drug cost. Beginning in FY 2001, VERA patient classes for HCV patients have been developed at the Basic and Complex Care levels and are based on appropriate diagnosis and active drug therapy.

i. **Labor Adjustment.** Each VISN's allocation will be adjusted by a labor adjustment that represents its cost of labor relative to the national cost of labor. The labor adjustment will be a zero-sum adjustment at the national level, and is applied to a measure of labor dollars which, for FY 2002, is the normal pay for the most recent four pay periods in FY 2001 that are accessible and verifiable to the Allocation Resource Center (ARC). The FY 2000, geographic salary adjustment was changed to adopt the labor index methodology recommended by PricewaterhouseCoopers Limited Liability partnership (LLP) in the VERA Assessment Final Report. This methodology differs from the previous methodology in that it uses a national market basket approach in the formula to create the index, instead of network level staffing patterns. By using national data, the index formula does not intermingle staffing and salary variables. Therefore, the index is generated based upon specific differences in labor cost. The PricewaterhouseCoopers LLP methodology refines the computation of the labor index to include data related to salary and not network staffing patterns, producing a pure price index. This national market basket approach reflects the differences in geographic pay without introducing local staffing issues. In FY 2001, the workload factor for computing the labor index was changed to weight Complex Care patients approximately ten times more heavily than Basic Care patients in the application of the geographic price adjustment to account for a greater staff intensity for more complex patients. For FY 2002, the existing labor index is now applied to the cost of contracted labor and non-labor. These adjustments will account for expenses caused by geographic cost factors that are beyond a network's control.

j. **Research Support Funding.** Research support funding for each VISN is established using a nationally defined pool of resources and a nationally defined algorithm. Research support

resources are those that were reported in the Cost Distribution Report (CDR) in FY 2000. The research algorithm distributes resources using a national rate per VA and non-VA funded research. VA and non-VA funded research resources were determined by the Office of Research and Development for FY 2000. In FY 2002, the workload allocation factor for the distribution of the Research Support funding continues to reward VA-administered Research. The workload allocation factor for the Research Support component credits VA-administered research at 100 percent; non-VA funded, non-VA administered, peer reviewed research at 75 percent; and other non-VA funded, non-VA administered, non-peer reviewed research at 25 percent. For FY 2000, the Acting Under Secretary for Health approved the recommendation that Networks 'pass through' the research support VERA allocation as it is computed for each medical center 'Care Line,' or 'Product Line.' Each medical center must explicitly obligate and account for VERA research support funds allocated to support the salaries of researchers, research facilities, and administrative costs. This facility level allocation occurs again in FY 2002, as VHA will continue last year's policy to pass the VERA research support allocation to the medical centers in FY 2002. Networks must again provide a report that justifies any variances from the assigned research support allocations by facility.

k. **Education Support Funding.** Education Support funding for each VISN is established using a nationally defined pool of resources and nationally defined algorithm. Education support resources are those that were reported in the CDR in FY 2000. The education support algorithm distributes resources using a national rate per resident position. Resident positions are those positions distributed to each VISN by the Office of Academic Affiliations for the academic year 2001-2002.

l. **Equipment Funding.** In FY 1997 and FY 1998 Equipment funding (Object Class 31) was based on clinical complexity data (weighted score of 50 percent), unique patient count by Network (weighted at 25 percent), and the Consolidated Memorandum Receipt (CMR) historical purchase rate as a measure of current equipment (weighted at 25 percent). Beginning in FY 1999, the equipment funding was changed to recognize the need to fund patients, not facilities, and gradually phase equipment funding into the VERA Basic and Complex Care elements. The equipment funding algorithm was revised to use the Basic and Complex Care workload for each Network as the distribution factor. The equipment funding revision was phased in over a 2-year period. In FY 1999, 50 percent of the difference between the equipment funding methodology in FY 1997, FY 1998, and the revised method in FY 1999, was used to allocate equipment funds to Networks. In FY 2000, FY 2001, and FY 2002, the equipment allocation is based totally on Basic and Complex Care workload.

m. **Non-recurring Maintenance and Repair (NRM).** In FY 1997 and FY 1998, NRM funding (Object Class 32) was based on 90 percent of the Boeckh (square footage) Index and 10 percent on the national pricing pool of funding. In FY 1999, the NRM funding was changed to fund patients, not facilities, and adjusted for differences in regional construction costs. This was accomplished by using the Basic and Complex Care workload for each Network, and the portion of the Boeckh Index that adjusts for the cost of construction; phasing this in over 3 years in equal increments by adding 33 percent of the difference between the NRM methodology in FY 1997 and FY 1998, and the revised method in FY 1999, 66 percent in FY 2000, and 100 percent in FY 2001. FY 2001 was the first year that the NRM allocation was based solely on Basic and

Complex Care workload with an adjustment for differences in regional construction costs.

2. FORMAT OF THE NETWORK ALLOCATION

a. **Section I.** General Purpose includes: Patient Care Resource funds that are composed of Basic and Complex Care; a labor adjustment; Research and Education Support; Capital Assets, composed of funding for equipment, and NRM projects that will become capitalized assets.

b. **Section II.** Travel is composed of funds for employee travel.

3. NETWORK TO FACILITIES ALLOCATION. This information must be submitted in the following format to the VHA Office of Finance (172) no later than 21 calendar days after a network receives its final allocation. In providing this information for its FY 2002 allocation, networks must:

a. Provide a facility specific distribution of its VERA allocation.

b. Identify and briefly describe the approach used to allocate its funds to facilities, to include:

(1) Modified version of VERA-Capitation.

(2) Building upon the facilities' FY 2001 budgets.

(3) A combination of 3b(1) and 3b(2).

(4) Other (explain).

c. Briefly describe how its allocation model adheres to each of the following allocation principles as outlined in VHA Directive 97-054, it must:

(1) Be readily understandable and result in predictable allocations.

(2) Support high-quality health care delivery in the most appropriate setting.

(3) Support integrated patient-centered operations.

(4) Provide incentives to ensure continued delivery of appropriate Complex Care.

(5) Support the goal of improving equitable access to care and ensure appropriate allocation of resources to facilities to meet that goal.

(6) Provide adequate support for the VA's research and education missions.

(7) Be consistent with eligibility requirements and priorities.

(8) Be consistent with the network's strategic plans and initiatives.

(9) Promote managerial flexibility (e.g., minimize "earmarking" funds) and innovation.

(10) Encourage increases in alternative revenue collections.

d. Briefly describe its network reserve in terms of size, rationale for allocation to facilities, and expected release timing.

e. Briefly explain how its allocation process ensures equity as defined in Public Law 104-204 (i.e.,…to ensure that veterans who have similar economic status and eligibility priority and who are eligible for medical care have similar access to such care…).

f. Within 1 week after approval of its proposed facility specific allocation, provide a quarterly distribution of these budgets to the Resource Allocation and Analysis Office (172) for input into the Automated Allotment Control System (AACS).

4. MEDICAL CARE PROGRAM NOTES

a. **Full-time Equivalent (FTE) Employment.** In FY 2002, FTE levels will not be assigned during the budget process. Any required accountability and control of supportable FTE will be accomplished at the VISN level. Readjustment Counseling (25), Health Professions Education Programs (26), and other programs with specific FTE are not in the Network Allocation. They will be identified in subsequent funding actions. Networks will not be assigned a personal services floor. Adequate personal services should be budgeted to support planned employment levels.

b. **Funding for Specialized Programs**. Programs such as Post-traumatic Stress Disorder, Substance Abuse, and Homeless Veterans, whose workloads are captured in the VERA model are included in Section 1 of the Network Allocations. A portion of the allotments provided on the Network Allocation in Section 1 will be made available to these programs. Additional funding adjustments may be accomplished during the fiscal year. Funds received after the Network Allocation, which are allocated for a specific program, must be used for that program or returned to the VHA Central Office program office that provided them.

c. **Medical Care Collections**. In FY 1997, Public Law (Pub. L.) 105-33 established the Medical Care Collections Fund (MCCF). Effective July 1, 1997, Pub. L. 105-65 authorized the transfer of collections in the fund to the Medical Care Appropriation where they remain available until expended. Public Law 106-117, signed November 30, 1999, directs these collections be returned to the collecting facility. ***NOTE:*** *This was effective beginning with the November 1999 collections.*

d. **Capital Assets.** Funds identified in the FY 2002 Network Allocation for Equipment and NRM are for Object Class 31 and Object Class 32, as defined in Office of Management and Budget (OMB) Circular No. A-11. As recommended in the Office of the Inspector General (OIG) Report, "Audit VHA Major Medical Equipment Acquisition (Number 5R4-E01-120)" dated September 29, 1995; VISNs are responsible for informing management at VA medical

facilities of the availability of 14-month funds and for developing a schedule detailing the release of funds for equipment acquisition. While the OIG recommendation is equipment-specific, the underlying concept, of encouraging the facilities to take advantage of the 14-month time frame for the planning and purchasing of equipment, applies to both Object Classes 31 and 32.

(1) The allocations for Object Class 31 equipment include: funding for equipment procured for existing facilities; ADP requirements; and activations projects. Allocations provided for equipment will normally be multi-year funds that will be available for 14 months beginning August 1, 2002. If available, 1-year equipment funds, while identified for equipment in their initial allocation, are not subject to the obligation requirements of the multi-year funds and may be used for expenditures other than Object Class 31.

(2) All allocations provided for the NRM program in the FY 2002 Network Allocation are multi-year Medical Care appropriation Object Class 32 funds that will be available for 14 months beginning August 1, 2002. VISNs must manage leasehold improvements (build out), emergencies, interim projects that arise during the period, and changes or modifications to approved projects, and they need to establish a contingency or "risk pool" for those purposes.

e. **The Health Professions Education Programs (Program 26).** The Health Professions Education Programs (Program 26) include Medical and Dental Residents, Specialized Fellows, Veterans Administration Learning Opportunity Residencies (VALOR), and Associated Health Trainees. The Office of Academic Affiliations (144) allocates funding and FTE for these programs except for the VALOR program, which is administered by the Health Care Staff, Development and Retention Office (10A2D). If trainee positions cannot be filled, local officials in conjunction with Fiscal Service, need to notify the appropriate office so that the resources can be redistributed according to national needs. ***NOTE:*** *Trainee positions may not be switched between specialties without prior approval.*

f. **The Employee Education Programs (Program 27).** Effective with FY 1999, Employee Education funds, except funds for operation of the Employee Education System (EES) and faculty travel, were moved into General Purpose for distribution by VERA or included in the VISN's travel allocation. This includes travel for participant attendance at EES activities, as well as all costs related to Executive Development and Administrative Trainees. Funds for EES staff, programming, operations, and faculty travel will continue to be funded through Specific Purpose.

g. **Non-VA Workload Programs.** Non-VA workload programs include the State Home (Program 24), Community Nursing Home Care (Program 24), Fee Medical, Fee Dental, and Contract Hospital Programs.

(1) Fee Medical, Fee Dental, Contract Hospital, and Community Nursing Home Care, while funded as part of the model, are still considered non-VA workload programs.

(2) The State Home Program will continue to be funded through Specific Purpose funds. Restrictions apply to the funding and the workload. If the actual census for any state home category varies from the assigned level, the program office must be contacted to make the appropriate adjustments to workload and funding levels.

h. **Employee Travel (Limitation .007)**

(1) **Facility Regular.** This allocation is provided to cover normal facility-directed employee travel requirements. This includes travel funds for attendance at conferences and participant attendance at EES activities.

(2) **All Other.** These allocations are provided for specifically identified employee travel such as Readjustment Counseling.

i. **Prosthetics.** For FY 2002, the prosthetics budget will continue to be centrally funded and funding for repair (BOC 2551-52) and purchase (BOC 2692-93) of prosthetic appliances and surgical implants, and home oxygen (BOC 272-2574 and 272-2674) will be provided as Specific Purpose funding. The Prosthetics and Sensory Aids Service (113) will monitor activity and expenditures and make budget adjustments as required.

j. **Leases.** In FY 2002, only the "Mega Leases" for Anchorage, Columbus, Honolulu, Las Vegas, Manila, the Northern California System of Clinics, and field-based National Programs will be supported by VHA Headquarters. All other lease expenses, including leasehold improvements (build-outs), will be supported at the VISN level.

k. **Items not Included in Network Allocation.** Allocations included in Sections I and II of the Network Allocation reflect the FY 2002 allocation for all Medical Care requirements except the following:

(1) **Allocations for Reimbursable Costs collected by VA Facilities.** As indicated in the OMB Circular A-34, funds must be collected from non-Federal sources during the fiscal year the receivable is established to receive credit for reimbursement. This has been modified by Pub. L. 104-262 which says: collections for the sharing of medical resources, Title 38 United States Code 8153 and TRICARE intermediaries are budgetary resources in the year they are collected, regardless of when the service was performed. Facilities will receive funding on a monthly basis in arrears for those actual earned and/or collected reimbursable costs recorded in the Financial Management system (FMS) Standard General Ledger accounts 425F (Federal Receivable-Reimbursements), 425G (Federal Collections- Reimbursements), and 425P (Non-Federal Collections-Reimbursements).

(2) **Permanent Change of Station (PCS).** VHA Central Office's funding for PCS is provided for senior management of field-based national programs and resident engineers. All other PCS expenses for field-based national programs are to be absorbed within the funds available to the program activity. Funds are provided in accordance with VA and Federal Travel Regulations. Requests for funding must include the:

(a) Program name,

(b) Incumbent's name,

(c) Position being filled,

(d) Reporting date,

(e) Itemized costs for salary,

(f) All other, and

(g) Travel.

l. **New Items Included in the Network Allocation**

(1) **Franchise Fund Activities.** Franchise Fund Activities to include:

(a) VA Records and Vault Storage in Neosho, MO.

(b) Security Office; i.e., background investigations.

(c) Law Enforcement Training Center - In-service training.

(d) Law Enforcement Training Center - Resident training.

(e) Austin Automation Center - Time share access.

(f) Austin Automation Center - Consolidated co-payment processing for 1st party collections.

(g) Austin Automation Center - Lockbox for 1st party debt remittance.

(h) Austin Finance Center - Payroll and accounting.

(2) **Medical Care Cost Recovery.** Medical Care Cost Recovery to include:

(a) Area Directors,

(b) Ft. Meade and/or Ellsworth,

(c) Multi-media development,

(d) Communications service, and

(e) Integrated Data Communications Utility (IDCU) Digital Equipment Corporation (DEC) Veterans Health Information System and Technology Architecture (VistA Hardware) Maintenance Contract.

(3) **Effective in FY 1999,** the following items, previously funded by Specific Purpose were shifted to General Purpose for funding from Network Allocations.

(a) Recruitment and retention tuition,

(b) Substance Abuse (Alcohol and Drug Halfway House),

(c) College of American Pathologists, and

(d) Administrative trainees.

(4) **Effective with FY 2000,** the following items, previously funded by Specific Purpose, were shifted to General Purpose for funding from Network Allocations:

(a) VISN Support Service Center.

(b) Contract Hospital; Brook Army Medical Center Sharing Agreement and Canadian Fee Program.

(c) Leases for locally-directed Research Activities. Several leases for locally-directed activities were funded from Specific Purpose in FY 1999. Specific Purpose funding was provided for these leases in FY 2000 at 50 percent of the FY 1999 funded level. Specific Purpose funds will not be provided beginning with FY 2001. These leases are located at Charleston, SC; Manchester, NH; Palo Alto, CA; Honolulu, HI; San Diego, CA; and Cleveland, OH.

(d) Prepayment Audit of Transportation Claims performed by Austin Finance Center.

(5) **Effective with FY 2001,** the following items, previously funded by Specific Purpose were shifted to General Purpose for funding from Network Allocations:

(a) Leases for Locally-directed Research Activities. Several leases for locally-directed activities were funded from Specific Purpose in FY 1999. Specific Purpose funding were provided for these leases in FY 2000 at 50 percent of the FY 1999 funded level. The balance of Specific Purpose funds was shifted to General Purpose beginning with FY 2001. These leases are located at Charleston, SC; Manchester, NH; Palo Alto, CA; Honolulu, HI; San Diego, CA; and Cleveland, OH.

(b) Homeless Initiatives. The FY 2000 budget included funding for the Homeless Providers Grant and Per Diem, Outreach and Community-Based Contract Residential Care, Compensated Work Therapy, Stand Down, Excess Equipment and Clothing Distribution, Program Monitoring and Evaluation, and Multifamily Transitional Housing programs. These programs were funded through Specific Purpose. Beginning in FY 2001, the Outreach and Community-Based Contract Residential Care, Compensated Work Therapy, and Stand Down programs were shifted to General Purpose.

NOTE: *No items have been identified for FY 2002 at this time.*

m. **Federal Employment Compensation Payment.** The Federal Employment Compensation Payment (FECP), decentralized beginning in FY 1996, continues to be funded from General Purpose funds and obligated at the medical center level. The initial costing of the FECP obligation is charged to cost center 8401 (Office of the Director). However, FECP is a cost of doing business that will be transferred from 8401 to the respective cost centers where the individuals generating the FECP charges are journalized.

ATTACHMENT B

FY 2002 NETWORK ALLOCATION GLOSSARY OF TERMS

1. Administrative Subdivision of Funds. An administrative subdivision of funds is any subdivision of an appropriation or fund, subject to the provisions of the Anti-deficiency Act, which makes funds available in a specified amount for the purpose of incurring obligations. Under the Department of Veterans Affairs (VA) administrative control of funds, only allotments are considered to be administrative subdivisions of funds. An example of an administrative subdivision of funds (Allotment) is the breakout of funds by activity (department or staff office) within the General Operating Expenses Appropriation. *(Source: MP-4, Part V, 1B.04.a.)*

2. Allocation. This term is used in two different ways:

a. It is used restrictively to mean the amount of obligation authority transferred from one agency, bureau, or account that is set aside in a transfer appropriation account (also known as an allocation account) to carry out the purposes of the parent appropriation or fund.

b. It is used broadly to include any subdivision below the sub-allotment level, such as subdivisions made by the agency financial plans or program operating plans, or other agency restrictions. *(Source: Office of Management and Budget (OMB) Circular No. A-34, Sec. No. 11.4.)*

3. Allotment

a. Allotment is the authority delegated by the head, or other authorized employee, of an agency to agency employees to incur obligations within a specified amount, pursuant to OMB apportionment or reapportionment action or other statutory authority making funds available for obligation. *(Source: OMB Circular No. A-34, Sec. No. 11.4.)*

b. It is an authorization by the Deputy Assistant Secretary for Budget to agency heads and staff office directors to incur obligations within specified amounts, during a specified period, pursuant to OMB apportionment or reapportionment action or other statutory authority making funds available for obligation. An allotment is an administrative subdivision of funds and therefore is subject to the provisions of the Anti-deficiency Act. *(Source: MP-4, Pt. V, Ch. 1, par. 1B.043.)*

4. Apportionment. An apportionment is a distribution made by OMB of amounts available for obligation in an appropriation or fund account into amounts available for specified time periods, programs, activities, projects, objects, or combinations thereof. The apportioned amount limits the obligations that may be incurred. *(Source: OMB Circular No. A-34, Sec. No. 11.4.)*

5. Appropriation. Authority given to Federal agencies to incur obligations and to make payments from Treasury for specified purposes. An appropriation act, the most common means of providing budget authority, usually follows the enactment of authorizing legislation, but in some cases the authorizing legislation itself provides the budget authority. *(Source: General*

Accounting Office (GAO)/Accounting and Financial Management Division (AFMD) - 2.1.1Budget Glossary.)

6. Allowance. An authorization by department (heads) and staff office (directors) to facility Directors and other officials, of obligation authority, showing the expenditure pattern or operating budget they will be expected to follow in the light of the programs and activities contemplated by the overall VA budget or plan of expenditures. *(Source: MP-4, Pt. V, 1B.04.d.)*

7. Fee Basis

a. A type of contractual arrangement on an individual basis, for an individual situation, for a designated period of time, and authorized via a VA Form 10-7079, Authorization for Fee Outpatient Medical Services, traditionally been that of Medical Administration Services (MAS) at most facilities. Due to mergers, reorganizations and restructuring, many MAS activities have ceased to exist and responsibility for the program has shifted to other areas of facilities. Use Budget Object Class (BOC) 2562 or 2570. *(Source: Health Administration Service.)*

b. A non-VA physician is brought into a VHA facility to treat a veteran patient. Use BOC 2561 or 2571.

8. General Purpose Funds. Allocated funds based on a methodology using quantifiable workload measures. These funds are provided to the networks at the beginning of the fiscal year, generally, without restrictions on how they can be spent. Example of an exception is multi-year funds restricted to equipment and lands and structures.

9. Patient Treated. This term is used in two different ways:

a. Traditional sense and used in computing a measure of work – total discharges plus patients remaining bed status plus patients remaining non-bed status.

b. More recently used to mean treatment of a specific veteran, which is also referred to as a unique or unique social security number (SSN).

10. Prorated Person (PRP). Computation based on share of a patient's national cost. At the national level, each SSN for whom VA has provided care counts as one PRP. Each VISN, providing care for the individual, is assigned a proportion of the PRP in relation to their share of the costs of care for the individual. *(Source: Allocation Resource Center Web Site.)*

11. Refund. A refund is a repayment of excess payments. The amount is directly related to previous obligations incurred and outlays made against the appropriation. Refunds are to be deposited to the credit of the appropriation or fund account charged with the original obligation and treated in the following manner:

a. Refunds collected by un-expired annual and multi-year appropriations and un-canceled no-year appropriations.

b. Refunds collected by expired annual and multi-year appropriations are available for upward adjustments of valid obligations incurred during the un-expired period, but are not recorded.

c. Refunds to canceled annual, multi-year, or no-year appropriations are required to be deposited in miscellaneous receipts in the Treasury. *(Source: OMB Circular No. A-34, Sec. No. 11.2.)*

12. Reimbursement. Reimbursement is the collection that is received by the Federal government as a repayment for commodities sold or services furnished either to the public or to another government account and that is authorized by law to be credited directly to specific appropriations and fund accounts. *(Source: GAO/AFMD-2.1.1Budget Glossary.)*

13. Specific Purpose. Specific purpose funds are allocated funds distributed to the networks or medical facilities over the course of the fiscal year for specific events and activities. The funded levels are determined by the need of the specific event or activity.

14. Unique Patient. A unique patient is an individual patient who can be identified by the presence of a singularly unique SSN. *(Source: Allocation Resource Center Web Site.)*